PERSONAL HEALTH HISTORY

Name:	**DOB:**
Allergies:	
What is your chief concern today?	

Check any symptoms you are currently experiencing:

- ☐ Fever
- ☐ Swollen Glands
- ☐ Sore Throat
- ☐ Rash
- ☐ Cough
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Shortness of Breath
- ☐ Sweating
- ☐ Indigestion/Heartburn
- ☐ Abdominal Pain
- ☐ Depression
- ☐ Suicidal Thoughts/Plans
- ☐ Anxiety/Panic Attacks
- ☐ Memory Problems
- ☐ Ear Ache
- ☐ Weight Loss
- ☐ Changes in Stools
- ☐ Frequent Urination
- ☐ Nausea/Vomiting
- ☐ Weakness/Falls
- ☐ Other Pain ______________________________

Do you or anyone else in your family have any of the following conditions?

Asthma ☐ Self ☐ Family ______________________________
Cancer ☐ Self ☐ Family ______________________________
Diabetes ☐ Self ☐ Family ______________________________
Epilepsy/Seizures ☐ Self ☐ Family ______________________________
Kidney ☐ Self ☐ Family ______________________________
Heart Disease ☐ Self ☐ Family ______________________________
High Blood Pressure ☐ Self ☐ Family ______________________________
Hepatitis ☐ Self ☐ Family ______________________________
Other ____

Health Habits: Do you use any of the following?

Nicotine ☐ Yes ☐ No If yes, do you use ☐ cigarettes ___________ packs per day
☐ chewing tobacco ☐ pipe tobacco

Alcohol ☐ Yes ☐ No If yes, ______rinks per day. Last use:_______________________

Other Drugs ☐ Yes ☐ No If yes, what drugs? ____

____

Last use: __________________________________

Female Health

Date of last menstrual period: ____
Date of last PAP: ____
What type of birth control, if any do you use? ____________________________________
Are you currently pregnant? ☐ Yes ☐ No If yes, how many months? ______________________

Hospitalizations/Surgeries/ER Visits

	Year

Date of last physical exam ____
Name and phone number of primary physician ___________________________________

____

In the past 6 months have you seen a healthcare provider? If yes, please explain.

____

____

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CURRENT MEDICATION/DRUG LIST

Name of medication or drug	Dosage	Schedule (ie: once a day, two times a day…	Do you take it consistently?	If prescribed, prescriber's name	Reason for prescription or for using?	How long have you been on it?	Have you ever taken more than prescribed?
			☐ Yes ☐ No				☐ Yes ☐ No
			☐ Yes ☐ No				☐ Yes ☐ No
			☐ Yes ☐ No				☐ Yes ☐ No
			☐ Yes ☐ No				☐ Yes ☐ No
			☐ Yes ☐ No				☐ Yes ☐ No
			☐ Yes ☐ No				☐ Yes ☐ No
			☐ Yes ☐ No				☐ Yes ☐ No
			☐ Yes ☐ No				☐ Yes ☐ No
			☐ Yes ☐ No				☐ Yes ☐ No
			☐ Yes ☐ No				☐ Yes ☐ No
			☐ Yes ☐ No				☐ Yes ☐ No